STATE OF MICHIGAN

GOVERNOR'S TASK FORCE ON CHILD ABUSE AND NEGLECT

AND

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES

PLAN OF SAFE CARE PROTOCOL

First Edition

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PLAN OF SAFE CARE: INTRODUCTION

A Plan of Safe Care (POSC) is a plan to address the needs of infants exposed to substances by offering services to families impacted by substance use during and following pregnancy. The POSC is developed to focus on the infant's ongoing health, development, safety, and well-being.

The federal National Center on Substance Abuse and Child Welfare (NCSACW) has summarized why Plans of Safe Care are necessary:

> "In 2016, the Comprehensive Addiction and Recovery Act modified child welfare legislation to expand POSC to include all infants affected by substance abuse withdrawals symptoms or a fetal alcohol spectrum disorder and who require services be identified for the family/caregivers of these infants. The Administration for Children, Youth and Families, Children's Bureau, which provides guidance related to POSC, has identified multi-system collaboration as a best practice to support affected infants and their families."

The Child Abuse Prevention and Treatment Act (CAPTA) requires that all states receiving grants must create a POSC to:

1. Address the health and substance use disorder treatment needs of the affected infant and family or caregiver.
2. Specify a system for monitoring the local provision of services in accordance with these requirements.

POSC desired results or outcomes include:

1. Keeping families together whenever possible.
2. Safely reunifying families as quickly as possible after removal has occurred.
3. Identifying prenatal substance exposure and engaging families in care.
4. Promoting substance use disorder treatment completion and engagement in recovery.
5. Ensuring children live in safe, stable, and nurturing environments.
6. Securing involvement of family members and support persons.

DEFINITIONS AS USED IN THIS PLAN OF SAFE CARE PROTOCOL

Child Abuse Prevention and Treatment Act (CAPTA) – Federal legislation addressing child abuse and neglect. CAPTA provides federal funding to states in support of prevention, assessment, investigation, prosecution, and treatment activities.

Comprehensive Addiction and Recovery Act of 2016 - CARA – The Comprehensive Addiction and Recovery Act (CARA) establishes a comprehensive, coordinated, balanced strategy through enhanced grant programs that would expand prevention and education efforts while also promoting treatment and recovery.

Evidence-Based Home Visiting – A research based, voluntary, prevention focused, service delivery strategy in which services are carried out primarily in the homes of families with children ages 0 to 5 years and pregnant individuals. Home Visiting programs employ well-trained, competent staff who deliver the program according to model fidelity to support pregnant individuals, infants, children, and their families to achieve positive outcomes.

Early On® - Early On – Michigan's system for helping infants and toddlers, birth to age 3, and their families who have developmental delays or are at risk for delays due to certain health conditions. It's designed to help families find the social, health, and educational services that will promote the development of their infants and toddlers with special needs.

The 5Ps Prenatal Substance Abuse Screen for Alcohol and Drugs – An effective tool of engagement for use with a pregnant individual who may use alcohol or drugs. This screening tool poses questions related to substance use by the pregnant individual's parents, peers, and partner, during pregnancy and in the past. These are non-confrontational questions that elicit genuine responses which can be useful in evaluating the need for a more complete assessment and possible treatment for substance misuse.

Health Care Providers – As used in this document, this includes doctors, SUD treatment providers, advanced practice professionals, nurses, midwives, doulas, and social workers.

Infant – Baby from ages one month through 12 months of age.

Intrapartum – Occurring or provided during the act of birth.

Meconium – Infant's first stool.

Michigan Department of Health and Human Services (MDHHS) – The principal department of the State of Michigan that provides public assistance, child and family welfare services, and oversees health policy and management.

Neonate/Newborn – Referred to as "newborn" in this document. Covers time of birth to one month of age.

Partners – As used in this document, this includes community-based agencies, parent advocacy groups, and health care providers.

Perinatal – Includes the time from 22 weeks of completed gestation through seven days after birth.

Plan of Safe Care (POSC) – A plan designed to ensure the safety and well-being of an infant with prenatal substance exposure following their release from the care of a health care provider by addressing the health needs of the infant, the treatment needs of the birthing parent and affected family or caregiver(s).

Prenatal – Defined as the time between conception and birth.

Primary Referral Sources – Entities that are in contact with pregnant or newly parenting individuals or infants affected by substance use, such as hospitals, health care professionals, childcare providers, public health facilities, home visiting programs, and other social service providers.

Postpartum – The time period from delivery through six to eight weeks after delivery.

Primary Stakeholder – Any person or group who plays a role in the creation or execution of the POSC, including but not limited to, MDHHS, health care professionals, parents, and caregivers.

Screening (verbal or written) – Initial assessment of prenatal substance use that identifies whether there may be or has been substance use and determines if there is a need for further risk assessment.

Substance Use Disorder (SUD) – A complex condition in which there is continued use of a substance despite harmful consequence.

Testing – Sample (urine/meconium/umbilical cord of newborn or urine/blood of birthing parent/fetal alcohol) evaluated for the presence of drugs and/or alcohol.

Warm Handoff – A discussion between one treatment provider and a new treatment provider, which includes the parent(s) and/or caregivers, in order for the parent(s) to hear the discussion between the providers.

GUIDING PRINCIPLES AND GOALS

The State of Michigan POSC guiding principles and goals are:

To maintain interagency agreements across health and social service agencies and to address the infants' and parents' physical, social-emotional health, and safety needs.

To develop an inclusive, family-centered approach that fosters a comprehensive understanding of substance use and misuse and its impact on infants, families, and caregivers. The POSC will aim to meet the needs of each family member by building on each family member's strengths and challenges.

To establish a model of education for primary stakeholders regarding substances, addiction, and potential risks to infants and their families and caregivers.

To encourage collaboration and care-coordination between relevant stakeholders while maintaining privacy and confidentiality in the development and implementation of the POSC.

To complete a risk assessment that is organized by the presence of protective factors that look at strengths and concerns of the parent(s), family members, and caregivers as part of their engagement in recovery.

To assure legally sound and data driven decision making that is inclusive of a trauma-informed lens, while maintaining family engagement throughout the entire process.

To offer supports and services to an infant, parent(s), caregivers, and household members during the first year of an infant's life.

Best Practice Tip: Early assessment and a long-term wraparound effort utilizing a multidisciplinary approach to best serve the infant, parent(s), and family are critical.

WHO CAN INITIATE A POSC

There are many paths to initiating and sustaining a Plan of Safe Care (POSC)

I. PRENATAL CARE

Early identification, screening, engagement, and referral of a pregnant individual who is using substances will allow the collaborative process to begin prior to the birth of the newborn.

Prenatal POSC are created by primary referral sources. The primary referral source is encouraged to work closely with hospital navigators, when available, to help facilitate the POSC process.

Best Practice Tip: All providers should be keenly aware of the impact of all forms of implicit and explicit biases impacting assessment, screening, and care decisions with families. Proactive responses should be integrated.

- Screen all pregnant individuals for substance use at the first visit, at every trimester, and at delivery.
- Educate on the impact of all forms of substance use including alcohol, cannabis, and illicit substances on pregnancy and breast/chest feeding.
- Assess for use prior to pregnancy. Ask about use prior to pregnancy awareness as well as current use.
- Make informed consent for screening a universal practice.
- Provide information and encourage permission for referrals throughout engagement.

Clinical Team Screening: The purpose of utilizing validated, universal screening such as the 5Ps (see appendix), is to mitigate and prevent negative outcomes, reduce bias, address risks early, and connect with family when the patient needs support for the well-being of all family members. If the screen is positive, procedures should include the following:

- Assess and Intervene
    - Have a resource guide available to all health care providers and encourage use of a validated tool, such as the 5Ps *Prenatal Substance Abuse Screen for Alcohol and Drugs (5Ps).*
        - Screening is intended to identify potential problematic substance use. (Diagnosis of a substance use disorder must occur by a trained professional.)
        - Resource guide should include local supports and treatment facilities in the community.
    - Share screening results and feedback with the patient.
    - Assess and validate the patient's reaction and discuss their feelings, thoughts, and fears.
    - Assess readiness to change.

- Advise
    - Provide assistance and information to the pregnant individual based on the risk assessment and readiness to change. Educate and provide resources sensitive to substance use and pregnancy. Collaborate on a plan with specific action steps.
    - Praise all efforts to seek help and change.

- Support and Arrange
    - Offer help. Ask what the pregnant individual will do and agree on a plan that can be incorporated into a POSC.
    - Praise all efforts to change.
    - Arrange for warm handoff and ensure the pregnant individual is aware of who will be providing specialty SUD treatment and provide information regarding the treating providers when possible.
    - Obtain consent/release for coordination with SUD treatment providers.
    - Provide overdose education and information on where to obtain Naloxone kits if opioid use is a concern.

- Manage Pregnancy-Related Medical Issues
    - Screen for untreated medical problems, injuries, and infections, as appropriate.
    - Screen for mental illness.
    - Screen for interpersonal violence and provide referrals.
    - Confirm needed enrollment for Methadone or Buprenorphine maintenance.
    - Schedule urine toxicology screens and monitor use.
    - Refer to The American College of Obstetricians and Gynecologists (ACOG) in appendix for guidance on parental consent.
    - Schedule regular visits to identify needs and concerns.
    - Monitor fetal growth, development, and well-being based on current substance use or abstinence.
    - Discuss possible effects on newborn.
    - Discuss birth plan, including pain management.
    - Discuss contraceptive methods.
    - Discuss pros and cons of breast/chest feeding and substance use.
    - Discuss lactation concerns and provide referrals, as necessary.
    - Consult and coordinate with addiction and mental health treatment providers.
    - Contact information for publicly funded substance use disorder treatment and mental health counseling can be found in the attached Resources section.

- Systems Collaboration
    - Family members/caregivers: During the prenatal phase, consider what supports can be offered to the family so that they can be a positive resource for the pregnant individual and infant.
    - When there is no MDHHS involvement, the primary referral source should promote interagency coordination/collaboration between primary stakeholders.

II. POSTPARTUM, CHILD STILL IN THE HOSPITAL'S CARE

Early identification, screening, engagement, and referral of individuals who have just given birth, and for whom there are substance use concerns, will allow the collaborative process to begin prior to the newborn going home from the hospital.

Best Practice Tip: Create a communication protocol between applicable agencies such as health care providers and the appropriate State of Michigan department that allows for timely information sharing and monitoring of infants and families across multiple systems.

- Delivering hospital should assist in the initial development of the POSC for birthing parent and infant identified at the time of delivery. If a POSC was created during the prenatal period, then the delivering hospital should continue to utilize and support the current plan.
- POSC should include individualized tools to ensure a greater likelihood of family stability and well-being with sufficient monitoring of maternal depression and anxiety, continuing recovery, and parental capacity to meet the infant's and birthing parent's needs.

Screening and Assessment: Recommend universal screening of all pregnant individuals for substance use at delivery including, but not limited to, utilizing the 5Ps.

- Develop protocol for consent and screening/testing.
- Review prenatal history regarding substance use.
- If no known prenatal care, then rely on hospital protocol for guidance on screening or testing of pregnant individual(s) as soon as possible.

Assessment options include, but are not limited to:

- Eat, Sleep, Console Program – Screen for signs of substance withdrawal.

Finnegan Test – "The Finnegan scale assesses 21 of the most common signs of neonatal drug withdrawal syndrome and is scored on the basis of pathological significance and severity of the adverse symptoms, which sometimes requires pharmacological treatment." (Johnson, L. (2021, September 02) *Neonatal abstinence syndrome* neonatal-abstinence-syndrome. - UpToDate

Testing options include:

- **Meconium:** "The detection window for most drugs of abuse in meconium and umbilical cord tissue testing is up to approximately 20 weeks prior to birth. Meconium begins to accumulate in the fetal gut near midterm of the pregnancy. Prior to this time frame there is no meconium to trap the drug or drug metabolites." (https://www.usdtl.com/blog/faqs/what-is-the-window-of-drug-exposure-for-drugs-of-abuse-in-meconium-and-umbilical-cord-tissue-and-why)
- **Umbilical cord:** "Umbilical Cord Testing uses 6 inches of umbilical cord tissue that has a window of detection up to approximately 20 weeks prior to birth. Umbilical cord blood has the same blood drug detection window as standard blood drug tests, up to approximately two to three days prior to collection." (Fleming, E. (2021, March 03) *What is a cord test?*
- **Urine:** "Urine drug testing is widely used in newborn drug testing but has a short detection window capturing maternal non-medical drug use up to three to seven days prior to delivery depending on the half-life of the drug." (Karen J. Farst, 2011)

Consent to Testing:

- Consent to test for substance use can be obtained from the parent verbally or in writing. This consent should be noted in the parent's electronic health record.
- Newborn testing ordered by a medical provider while providing care/treating the newborn does not require consent under the following circumstances:
    - Maternal indicators include, but are not limited to:
        - No prenatal care.
        - Reported drug use (unprescribed or misuse of prescribed drugs).
        - Drug screen positive for unprescribed drug (including marijuana).
        - Cerebral infarct(s) of unclear etiology.
        - Myocardial infarction of unclear etiology.

    - Neonatal indicators include, but are not limited to:
        - Jittery/tremulous in absence of hypoglycemia.
        - Unexplained irritability, seizures, or apneic spells in full term neonate.
        - Additional signs of withdrawal: wakefulness, hyperactive deep tendon reflexes, exaggerated Moro reflex, high pitched cry, excessive sucking, vomiting, diarrhea, rhinorrhea, diaphoresis, difficulty feeding (not in isolation).
        - *Necrotizing enterocolitis* (NEC) in full term neonate.
- Refer to the Newborn Drug Testing algorithm for more information. https://arupconsult.com/algorithm/newborn-drug-testing-algorithm.
- If the court has jurisdiction through an abuse/neglect case, then it possesses what is sometimes referred to as "incidental orders authority" and it may enter any order which "in the opinion of the court [is] necessary for the physical, mental, or moral well-being of a particular juvenile or juveniles under its jurisdiction." MCL 712A.6; see also, *In re CR*, 250 Mich App 185, 209 (2002) (Court of Appeals held family court's jurisdiction under this section is "tied to the children"); *In re Macomber*, 436 Mich 386 (1990) (same); 42 U.S.C. 678 ("Nothing in this part shall be construed as precluding State courts from exercising their discretion to protect the health and safety of children in individual cases . . .").

Release of Information:

- **MDHHS**: Because of the highly confidential status given to information concerning substance use disorder treatment, caseworkers must follow policy and only release this type of information under the provisions given; see SRM 131, *Confidentiality – Substance Abuse Records.*
- **Primary Medical Provider:** Newborn discharge summary should provide primary medical provider with the results from the hospital that includes information about the newborn, including maternal substance use and the need for medical follow-up of the exposed newborn.
- *Please see the Appendix for a sample Authorization to Release Confidential Information form.*

Mandated Reporting and Notification*:*

Mandated reporters who know, or from the infant's symptoms have reasonable cause to suspect, that an infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in the infant's body, **not** attributed to medical treatment, **must make a referral of suspected child abuse to Centralized Intake.**

Per CAPTA, a **notification to Centralized Intake** is required if the mandated reporter knows that the alcohol, controlled substance, or metabolite, or the child's symptoms are the result of medical treatment administered to the infant or the infant's parent. Medical marijuana and Medication-Assisted Treatment (MAT) are considered medical treatment.

CPS will investigate complaints alleging that an infant was born exposed to substances not attributed to medical treatment when exposure is indicated by any of the following:

- Positive urine screen of the infant.
- Positive result from meconium testing.
- Positive result from umbilical cord tissue testing.
- A medical professional reports that the child has symptoms that indicate exposure.

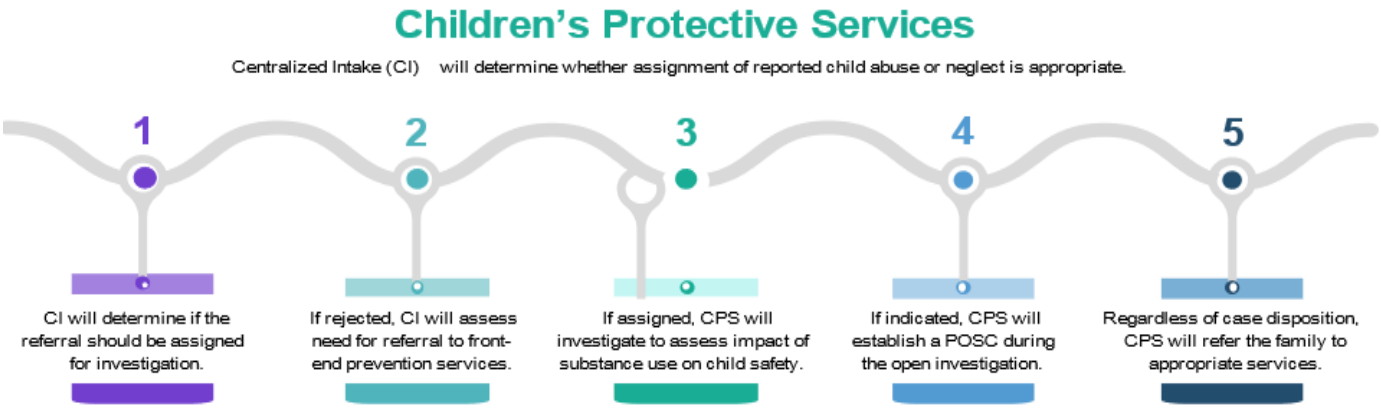
A notification to the department may not be assigned for investigation; however, it will allow for the coordination and implementation of a POSC, as required.

If the test is positive, then the following procedures should be implemented:

- Intrapartum:
  - Complete history and physical exam.
  - Repeat hepatitis screen, serologic test for syphilis, and HIV rapid test.
  - Repeat urine toxicology.
  - Alert appropriate health care providers.
  - Alert social services if necessary.
  - Continue Methadone or Buprenorphine on schedule in consultation with the birthing parent's treatment doctor.
  - Determine method of delivery depending on obstetrical indicators.
  - Pain management: assure pain will be managed. Maximize and schedule non-opioid analgesia and provide adequate opioid analgesia when indicated.

- Postpartum Care:
  - Encourage continuation in a therapeutic drug treatment program and coordinate with program, if applicable.
  - Provide close follow-up for pain management.
  - Consider more frequent postpartum visits.
  - Support breast/chest feeding as appropriate. Breast/chest feeding is typically recommended in Methadone or Buprenorphine maintenance but is contraindicated if the breast/chest feeding parent is HIV positive or using drugs (including marijuana) that may harm the infant or is otherwise contraindicated.

- Provide birthing parents with access to lactation consultation during and after infant's hospital stay.
- Support skin-to-skin care, swaddling, and calming techniques for the birthing parent to use with the infant.
- Provide new birthing parents education about safe sleep practices and resources.
- Coordinate with MDHHS for safe discharge plan in cases where CPS is involved.
- Consider appropriate referrals to home visiting programs.



MDHHS Duties:

- Centralized Intake:
  - Determine whether reported child abuse/neglect will be assigned for investigation or referred to another agency.
  - To assign for investigation, complaints containing allegations of substance use must meet Child Protection Law (CPL) definitions of suspected child abuse and/or neglect.
  - Cases involving substances: A complaint involving only alleged substance use is insufficient for investigation or confirmation of child abuse/neglect. Parents may use legally or illegally obtained substances and prescribed medications to varying degrees and remain able to safely care for their children. Substance use by a parent/caregiver may be a risk factor for child maltreatment. MDHHS Policy PSM 716-7
  - Coordinate with hospital/birthing center/doulas/midwives when possible.
  - Determine location of newborn and family.

- Assignment for CPS Investigation:
    - CPS will investigate to assess impact of substance use on child safety.
    - Substance use is a mental health disorder, and caseworkers should assist the parent/caregiver in accessing relevant supports and services.
    - If not already in place, CPS must establish a POSC during the open investigation.
    - Regardless of case disposition, services must be provided to the infant and family by MDHHS or another service provider.
    - If the investigation does not lead to a case being opened, CPS will refer to evidenced-based programming, including but not limited to: Early On, Home Visiting, substance use disorder prevention, treatment or recovery services, or family preservation programs.
    - If the case is determined to be a Category I, II or III, service providers will be identified to work with the family. Service providers include, but are not limited to: substance use services, behavioral health services, court services, drug court, or Families First.

Coordination of Services by the Health Care Provider:

- Develop a system of care to outline the connection and communication process between the hospital, the general pediatrician/family medical provider, and CPS, if CPS is involved.
- Standardize the process for identifying the family's needs, including how to determine appropriate referral of services.
- Create a set of questions and responses that will help CPS intake specialists assess risk and protective factors and safety concerns for the infant and birthing parent. (See Appendix for Centralized Intake Phone Staff – Reference Guide.)
- Create a comprehensive assessment of the infant's physical health and the birthing parent's physical and social/emotional health and parenting capacity. This will be used to develop a thorough discharge plan and inform a multidisciplinary POSC.

Legal Considerations:

- Court: The family court can provide leadership to ensure that linkages between systems and services occur.
    - Abuse/neglect case: POSC can be incorporated into the safety plan and into the dispositional order with a parent – agency treatment agreement. The court can inquire about progress with the POSC and can enforce the provisions once it is included in the court order.
    - Criminal/juvenile probation case: If it comes to the court's attention that the birthing parent has a POSC, then the court could require compliance with the POSC as terms of the probation order.
    - Friend of the Court (FOC) case: If during the establishment of a FOC case, it comes to the court's attention that there is a POSC, it is feasible that the court could enter the contents of the POSC into the court order on paternity/custody/parenting time.

III. POSTNATAL, NEWBORN/INFANT HAS LEFT THE HOSPITAL

Continued screening, engagement, and referral of an individual who has just given birth, and about whom there are substance use concerns, will allow the collaborative process to continue after the baby is discharged from the hospital.

POSC must include:

- The health and safety needs of the infant.
- The health and substance use treatment needs of the birthing parent or caregiver.
- The needs of all household members and social supports.

Available Services: Referral and implementation of these services are the responsibility of the MDHHS caseworker or other service provider. Service providers include, but are not limited to:

- Early On.
- Michigan Home Visiting Program.
- Families First.
- Families Together Building Solutions (FTBS).
- Substance use disorder prevention, treatment, or recovery.
- Family Preservation.

NOTE: Available service providers will vary based on area.

Family Supports:

- Stakeholders will work with families to identify systems of support.
- Expand treatment opportunities for families.
- Provide necessary resources, including but not limited to:
    - Transportation, childcare, housing, financial support, and safe sleep.
    - Local Programs – Early On, Mom Power, and evidence-based Home Visiting programs.

Testing and Assessment:

- For cases where CPS or Foster Care is involved, MDHHS caseworker has the responsibility to determine if substance/alcohol tests are necessary for parents or other persons responsible for the infant/child.
    - Testing should be conducted in accordance with MDHHS policy and court order.
    - Testing is obtained to aid in treatment planning for the health and safety of the parent and infant and is not meant to be punitive.
- Regardless of the test results, caseworkers must continuously engage with the parent, provide the parent with applicable services, and assess the impact of the parent's substance use on child safety.

Consent:

- Federal regulations require that the civil rights of a client be protected. Informed consent is a mandatory component of substance/alcohol testing procedures and caseworkers must

ensure that a consent form is signed. The person tested must be provided with information on the potential subsequent action of testing.
- If the parent does not consent to testing, the caseworker should engage with them and continue to assess for potential risks to the newborn.

Release of Information:

- **MDHHS**: Because of the highly confidential status given to information concerning substance use disorder treatment, caseworkers must follow policy and only release this type of information under the provisions given; see SRM 131, *Confidentiality – Substance Abuse Records.*
- **Primary Medical Provider:** The newborn discharge summary should provide the primary medical provider with the results from the hospital that includes information about the newborn, including maternal substance use and the need for medical follow-up for the exposed newborn.

Legal Considerations:

- Court: The family court can provide leadership to ensure that linkages between systems and services occur.
    - Abuse/neglect case: POSC can be incorporated into the safety plan and into the dispositional order with a parent – agency treatment agreement. The court can inquire about progress with the POSC and can enforce the provisions once it is included in the court order.
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IV. TRAINING/EDUCATION

Best practice tip: Provide training to primary stakeholders on the following information, as applicable:

- What is a POSC?
    - Difference between POSC and safety plan.
- How providing supports and preventative prenatal POSC can reduce disproportionality.
- Depression/postpartum mood disorders and anxiety and how they may increase substance use.
- Training on how to support substance-exposed infants, to include ensuring the infants are achieving developmental milestones.
- Maternal mortality – provide data and information regarding maternal mortality during the first year postpartum.
- Role of Medication-Assisted Treatment (MAT) in addiction.
- Biology of addiction, including signs and symptoms of different substances.
- Provide education on supporting families affected by Perinatal Substance Use Disorder (PSUD).
- Impact of systemic racism on access to and obtaining health care.
- Role of implicit bias.
- Possible impact of the following on substance use:
    - LGBTQIA+.
    - Human trafficking.
    - Social Determinants of Health (SDOH).
    - Intimate Partner Violence (IPV).
    - Trauma/ACEs.
- Specific training for parents/caregivers, including but not limited to:
    - Drug use and impact on infant.
    - MAT.
    - Benefits of breast/chest feeding.
    - Techniques to calm and nurture a substance withdrawing infant.
    - Coping skills.

- Mandated Reporting - When and how to report suspected neonatal exposure to substances.

Mandated reporters who know, or from the infant's symptoms have reasonable cause to suspect, that an infant has any amount of alcohol, a controlled substance, or a metabolite of a controlled substance in the infant's body, **not** attributed to medical treatment, **must make a referral of suspected child abuse to Centralized Intake.**

Per CAPTA, a **notification to Centralized Intake** is required if the mandated reporter knows that the alcohol, controlled substance, or metabolite, or the child's symptoms are the result of medical treatment administered to the infant or the infant's parent. Medical marijuana and Medication-Assisted Treatment (MAT) are considered medical treatment.

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A notification to the department may not be assigned for investigation; however, it will allow for the coordination and implementation of a POSC, as required.

If the test is positive, then the following procedures should be implemented:

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    - Complete history and physical exam.
    - Repeat hepatitis screen, serologic test for syphilis, and HIV rapid test.
    - Repeat urine toxicology.
    - Alert appropriate health care providers.
    - Alert social services if necessary.
    - Continue Methadone or Buprenorphine on schedule in consultation with the birthing parent's treatment doctor.
    - Determine method of delivery depending on obstetrical indicators.
    - Pain management: assure pain will be managed. Maximize and schedule non-opioid analgesia and provide adequate opioid analgesia when indicated.

APPENDIX

I. Sample POSC Template

Michigan Plan of Safe Care Sample Template

II. Mother & Baby Substance Exposure Initiative Protocols, Guidelines, & Safety Bundles

Mother & Baby Substance Exposure Initiative Protocols, Guidelines, & Safety Bundles

III. Centralized Intake Phone Staff

Centralized Intake Reference Guide - Substance Use Referrals

IV. Sample DHS 1555-CS Authorization to Release Confidential Information

Sample DHS 1555CS - Authorization to Release Confidential Information

V. Citizen Review Panel Annual Report on Plans of Safe Care: 2019

Citizen Review Panel Annual Report on Plans of Safe Care 2019

RESOURCE PAGE

National Resources

1. Home | National Center on Substance Abuse and Child Welfare (NCSACW) (hhs.gov) Provides expertise and technical assistance to support states on developing POSC.

   NCSACW recommends the following components:
   - Cross system partnership.
   - Governor's office support.
   - Clear guidance.
   - Local implementation teams: community-based teams.

2. Substance Abuse and Mental Health Services Administration (SAMHSA): Find a state-licensed treatment facility – SAMHSA's National Helpline: 1-800-662-HELP (4357).

3. Maternal and Child Health Bureau | MCHB (hrsa.gov) Find a local health center for primary health care, telehealth services, and COVID-19 testing sites.

4. The American College of Obstetrics and Gynecology – Informed Consent and Shared Decision Making in Obstetrics and Gynecology: https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2021/02/informed-consent-and-shared-decision-making-in-obstetrics-and-gynecology.

5. CHARM Case Study – A case study of a successful collaborative serving pregnant women with opioid dependence, their babies, and families.

6. PI-17-02 | The Administration for Children and Families (hhs.gov) Guidance from the U.S. Department of Health and Human Services – Administration for Children and Families (ACF) to states on implementing provisions in the Child Abuse Prevention and Treatment Act (CAPTA) as amended by CARA, relating to infants affected by substance use disorders.

State/Local Resources

1. Home | Michigan 211 (mi211.org) – An easy way to connect with help of all kinds, right in the community.

2. Early On (referral system set up specifically for MDHHS child welfare workers). If making a referral outside of MDHHS, please use the phone number or website below.

   Email: eoreferral@edzone.net

Toll Free: 1-800-EarlyOn (1-800-327-5966)

Website: Early On | Referral (1800earlyon.org)

Fax: (517)668-0446

Address: 240 S. Bridge St., Suite 250, Dewitt, MI 48820

3. Contact information for publicly funded substance use and mental health services can be found at: Get Help Now -Behavioral Health (michigan.gov)

4. MI Bridges (michigan.gov): MI Bridges can help access more than 30,000 state and local services across the state.

5. MDHHS Home Visiting Models: Michigan supports eight different Home Visiting Models. Please check Home Visiting (michigan.gov) to see what programs are available.

6. Michigan Guide to Creating a Collaborative Approach to Supporting Families with Babies with NOWS* (mphi.org)

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